TARO LEAF ACUPUNCTURE
PHONE:510.730.0608
EMAIL: info@taroleafacu.com

CONFIDENTIALITY
Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide care, or under your written authorization, or when required by law.

PEDIATRIC INTAKE FORM (Please Print and fill out form) ____New Patient

Todays Date:		
Patients Name (first, last):		
Birth Date:	Age:	Gender
Parents Name:	Phone:	
Address:		Zip
Emergency Contact	Relationship	
Emergency phone:		

Main Concerns and Symptoms
Medications:
Medical History
Family Medical History:

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, if necessary including needling, moxabustion, cupping, acupressure, light therapy, electroacupuncture and other techniques within the scope of the practice of Acupunture.

I have been advised that all insertion needles are pre-sterilized and disposable therefore the risk of infection is extremely rare. I further understand that there is the possibility of temporary complications that may result from an acupuncture treatment, which include, but are not limited to, fainting, minor bleeding or bruising, minor pain or soreness, nausea, weakness, fatigue, fainting, or shock.

There are cases where symptoms may get worse before they get better and I understand that if my condition worsens, I should get in touch with my Acupuncturist and/or seek other appropriate medical care.

I further state that the following conditions do not exist in my current state of health and that I will immediately notify my practitioner of any changes regarding the following:Pregnancy, bleeding disorders, seizure disorders, pacemaker, elevated risk of infection and local infection.

I have read the above consent form. I have had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedure. I understand that I can refuse treatment at any time.

Patient name:	Date:
Patient Signature (Patient Representative):	